

SPRED
SPECIAL RELIGIOUS EDUCATION
ARCHDIOCESE OF INDIANAPOLIS

SPRED CENTER LOCATION _____

Please fill out this form as completely as possible. All information will be kept confidential.

Name _____ Gender _____

Address _____

Phone no. _____ Date of Birth _____

Person to be contacted in case of an emergency _____

Emergency contact phone no. _____

What is the primary disability of the applicant? _____

Briefly describe any behavioral or emotional difficulties of the applicant. This information will assist us in preparing a safe and welcoming environment to our friends with special needs.

Describe any behavior "triggers" _____

Describe intervention / calming strategies _____

Applicant's religious affiliation: _____

Name and location of parish/church which applicant attends _____

(This information will help us prepare our sessions for all members of our communities.)

Sacramental History:

If applicant or parents of applicant are seeking preparation for sacraments in the Catholic Church, please provide the following information.

Has the applicant been baptized? _____ If yes, please provide the church name and location: _____

Other sacraments:

Eucharist: Yes No (Date and location) _____

Reconciliation: Yes No (Date and location) _____

Confirmation: Yes No (Date and location) _____

Is the applicant seeking preparation for any of the sacraments, if so which ones?

Please complete the following information so that we may be sensitive to the needs of our special friends during the SPRED sessions.

Does the Applicant:

Use a cane or walker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Use a wheelchair	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Have normal vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Have normal hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Can talk, with difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Can communicate needs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Need restroom assistance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Can eat without assistance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Need a straw for drinks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Have difficulty chewing			
or swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Have food allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
Have seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____

Please list any SPECIAL INSTRUCTIONS for any of the above listed needs:

Application completed by: _____

Relationship to applicant _____

Phone no. _____ Date _____